Supreme Court, U.S.
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No. ——

IN THE
Supreme Court of the United States

KRIS NELSON,
Petitioner,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, INC.,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the remedy provisions of ERISA are exclusive and preempt a claim based on a state law which regulates insurance within the meaning of ERISA's savings clause.

2. Whether a state tort claim for insurance bad faith which is applied only to insurance claims is a law regulating insurance within the meaning of ERISA's savings clause.

PARTIES

The Petitioner is Kris Nelson ("Nelson").

The Respondent is UNUM Life Insurance Company of America, Inc. ("UNUM").

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PETITION FOR A WRIT OF CERTIORARI

Nelson respectfully submits that a writ of certiorari should issue to review the denial of her petition for a writ of mandate by the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The Order of the Court of Appeals is reprinted in the Appendix ("App.") at 1a. The District Court's order denying in relevant part plaintiff's motion to amend is reprinted at App. 2a.

JURISDICTION

The United States Court of Appeals for the Ninth Circuit's order denying Nelson's writ of mandate was filed on December 20, 1999. This petition is being timely-filed within 90 days of that date. This Court has juridiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the statutes and regulations set forth at App. 8a to 49a.

STATEMENT OF THE CASE

A. Introduction

This case directly presents the question this Court declared unsettled in *UNUM Life Ins. Co. v. Ward*, 119 S.Ct. 1380 (1999). It is a question of vital national importance which affects millions of insured Americans. The appropriate scope and breadth of the preemptive effect of ERISA over state laws regulating insurance is in a state of massive confusion and conflict among and within the federal circuits as well as the state appellate courts. Until *Ward*, all courts which have attempted to define the scope of ERISA preemption in this context have relied on this Court's opinion in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), as the foundation for their analyses.

However, in their attempts to wrest clarity from the " 'veritable Sargasso Sea of obfuscation' that is ERISA preemption law," *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 717 (2d Cir. 1993), *rev'd sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), the Ninth and Second Circuit have issued directly contrary opinions and most of the other circuit courts have issued ambiguous opinions which have been subject to varying interpretations. State appellate courts around the country have experienced a similarly confounding attempt to elucidate ERISA's preemptive scope.

Moreover, the United States Solicitor General has urged this Court in *Ward* that there are "substantial reasons" to "reconsider part of the rationale of its decision in *Pilot Life*. . . . *Pilot Life* has been read to preclude even state law causes of action arising under laws that 'regulate insurance'. That portion of *Pilot Life's* rationale is, however, in significant tension with the text of [ERISA's] savings provision." 1998 WL 839957, *20.

In the context of this collective confusion regarding the question of the exclusivity of ERISA's enforcement provisions over state laws expressly carved out from preemption by the savings clause, this Court decided *UNUM Life Ins. Co. v. Ward*, 119 S.Ct. 1380 (1999). *Ward* made clear that most courts have incorrectly interpreted this Court's decision in *Pilot Life* to conclude that even laws which are saved from preemption are nonetheless preempted if in conflict with ERISA's enforcement scheme. However, by only stating what *Pilot Life* did *not* say, *Ward* raised the question of alternative enforcement mechanisms without answering it. Federal and state courts across the country are now continuing to shoot at the appropriate analysis of ERISA's savings clause in the dark. Yet, the most that they can do is attempt to predict this Court's ultimate resolution of the issue because it is the meaning of the Court's decisions in *Pilot Life* and *Ward* which must

serve as the bedrock for any other court's resolution of the issue.

Unfortunately, the burden of this disarray is borne too often by the sick and infirm, whose rights to pursue their insurance benefits under substantive state law hang in the balance. Those within the jurisdiction of the Ninth Circuit have the misfortune of living under the broadest interpretation of ERISA preemption set forth in *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989). *Kanne* held that, under the rationale of *Pilot Life*, laws which are within the savings clause are nonetheless preempted by ERISA if they provide remedies other than those provided in ERISA. Yet, *Kanne* is now in direct conflict with *Ward*, which stated, in effect, that *Kanne's* interpretation of *Pilot Life* was an unwarranted extension of this Court's opinion in that case. In addition to a direct conflict between the Ninth and Second Circuits, discussed *infra*, other circuit courts which purport to follow *Pilot Life's* exclusive enforcement rationale as well as the majority of state cases on the issue are now also in apparent conflict with *Ward*. Moreover, *Ward* has led to intra-circuit conflicts and to developing conflicts between district courts around the country which are now attempting to decipher the interplay between *Ward* and *Pilot Life*.

This Court is faced with a state of growing national confusion and tidal wave of litigation over the question Nelson represents in this petition for a writ of certiorari. As is evident from both pre-*Ward* and post-*Ward* cases, this controversy simply cannot and will not be resolved until this Court answers the questions raised by its prior decisions.

B. Factual Background

On May 7, 1996, Nelson filed an action in the Superior Court of the State of California in and for the County of Santa Clara against UNUM LIFE INSURANCE COM-

PANY OF AMERICA, INC. ("UNUM"). Therein, Nelson alleged that her employer, Nelson Analytical, Inc., purchased from UNUM a policy of disability insurance in which UNUM agreed to pay Nelson a monthly benefit if she were disabled.

On July 7, 1985, Nelson was severely injured in an automobile accident when the brakes of the car in which she was traveling failed as she was exiting a freeway, causing the car to swerve off the freeway and crash into a tree. Petitioner suffered a shattered or "burst" L4 vertebra, four fractured vertebrae, a fractured skull, and internal injuries resulting in permanent paralysis of her bladder and bowed function. Nelson submitted a disability claim to UNUM, which approved coverage and commenced monthly benefits. Despite having submitted dozens of medical reports documenting her total, permanent disability, on December 29, 1995, UNUM terminated Nelson's benefits allegedly on the grounds that it had insufficient information to support her continued dis ability.

In addition, UNUM—without any basis for suspicion of dishonesty—had its investigators sneak into Nelson's private wedding party and surrepitiously videotape her during the wedding reception. UNUM investigators also came onto the private grounds of her apartment complex and videotaped her with zoom lenses through her living room window.

C. Proceedings Below

Nelson's Complaint contained state law causes of action for invasion of privacy, intentional and negligent infliction of emotional distress, breach of the covenant of good faith and fair dealing (insurance bad faith) and violation of California's Unfair Business Practices Act (Cal. Bus. & Prof. Code § 17200 *et seq.*).

UNUM removed the case to federal court on November 18, 1996. On November 26, 1996, UNUM moved to

dismiss all of Nelson's claims alleging that her claims were preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

ERISA contains a preemption clause which provides that its provisions preempt any conflicting state laws. ERISA § 514(a), 29 U.S.C. § 1144(a). ERISA also contains a "savings" clause, which excludes from the effect of the preemption clause any laws regulating insurance. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

UNUM argued that Nelson's claim for insurance bad faith did not fall within the savings clause. Nonetheless, even if it did, UNUM claimed that it was still preempted. UNUM urged that ERISA's enforcement provisions were exclusive and thus preempted all state laws which provide a remedy other than those provided in ERISA—even if these state laws fall within the savings clause.

For its authority, UNUM relied primarily upon this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), as well as the Ninth Circuit's decision in *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989), and their progeny.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court held that a claim for tortious denial of insurance benefits filed under a Mississippi law was preempted by ERISA because the Mississippi law did not adequately regulate insurance and thus did not fall within the savings clause. This Court found further support for its conclusion in the fact that the Mississippi tort law was a law of general application which provided a remedy outside ERISA's exclusive remedial provisions.

In *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), the insureds contended that their claim under the California Insurance Unfair Prac-

tices Act (Cal. Ins. Code § 790.03(h)) was not preempted pursuant to the decision in *Pilot Life* because, unlike the Mississippi claim in *Pilot Life*, the Kannes' claim was made pursuant to a specific law which regulated insurance. The insureds contended that such claims were "saved" from preemption under the express language of the savings clause.

The Ninth Circuit disagreed, holding that, according to its reading of *Pilot Life*, even if the California Insurance Unfair Practices Act fell within the savings clause, it was nonetheless preempted because it provided a remedy other than those provided under ERISA's statutory remedial provisions. For this decision, the Ninth Circuit relied exclusively on this Court's ruling in *Pilot Life*.

On April 11, 1997, the District Court, relying on *Kanne*, granted UNUM's motion in part and denied the motion in part. It held that Nelson's causes of action for breach of the covenant of good faith and fair dealing and unfair business practices were preempted by ERISA. However, it held that the causes of action for invasion of privacy and negligent and intentional infliction of emotional distress were not preempted to the extent that they were based on the emotional distress claims inflicted as a result of any invasion of privacy and related claims. The District Court held that these claims were too attenuated from the ERISA claim to be swept within ERISA's preemption clause.

In accordance with that order, Nelson filed a First Amended Complaint on May 1, 1997, including a claim to recover benefits under ERISA and re-alleging the state law causes of action for invasion of privacy and negligent and intentional infliction of emotional distress.

On April 20, 1999, this Court issued its decision in *UNUM Life Ins. Co. of America v. Ward*, 119 S.Ct.

1380 (1999). That case clearly stated that the issue which the *Kanne* court and other courts had assumed was resolved in *Pilot Life* was, in fact, still an open question. The *Ward* Court further stated that the Solicitor General, upon whom this Court relies heavily, urged the view that ERISA's remedy provisions do not preempt state laws which fall within the savings clause. It was thus clear that *Kanne's* extrapolation of *Pilot Life's* holding was in conflict with *Ward.*

Accordingly, on June 4, 1999, Nelson moved to amend her complaint to include her state law claim for breach of the covenant of good faith and fair dealing. Nelson contended that *Ward* disputed the fundamental holding of *Kanne* and that, pursuant to *Ward,* her claim for breach of the covenant of good faith and fair dealing now must be considered to lay outside of ERISA's preemptive sweep.

Nelson's argument regarding *Ward's* profound impact upon preemption did not persuade the District Court below. On September 22, 1999, the court denied Nelson's motion to amend. App. 2a. The District Court rejected Nelson's contention that *Ward* had any impact upon the question of whether the California's law of insurance bad faith regulated insurance and therefore was saved from preemption. The District Court also rejected the claim that *Ward* found the question of whether ERISA's remedial provisions were exclusive to be an open one. Instead, it found that *Ward* merely "recalls and approves *Pilot Life's* holding that ERISA displaces state causes of action." App. 6a. It concluded that "courts have consistently interpreted ERISA's text and legislative history as manifesting a Congressional intent to occupy the field of employee benefit plan administration." *Id.*

On October 21, 1999, Nelson filed a petition for writ of mandate with the Ninth Circuit seeking an order directing the trial court to allow her leave to amend to add her

insurance bad faith cause of action in light of *Ward*. On December 20, 1999, the Ninth Circuit denied Nelson's writ petition.

REASONS THE PETITION SHOULD BE GRANTED

I. THERE IS A GREAT SPLIT AMONG AND WITHIN THE CIRCUITS REGARDING THE IMPORTANT FEDERAL QUESTION OF THE SCOPE OF ERISA PREEMPTION.

A. ERISA Preemption Principles

ERISA is a statute intended to protect employees. Its purpose is to protect employee pension and benefit plans, which were not adequately being protected by employers. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); 29 U.S.C. § 1001(b). Congress expressly declared a policy of protecting "the continued well-being and security of millions of employees and their dependants." 29 U.S.C. § 1001. ERISA applies to benefits which accrue to an employee pursuant to an employee benefit plan which is established or maintained by an employer with the purpose of providing benefits to its employees. *Shaw*, *supra*, 463 U.S. at 96-97; 29 U.S.C. § 1002(1). These benefits may include disability benefits provided by the employer through the purchase of insurance.[1]

ERISA contains two provisions pertinent here, the preemption clause and the savings clause. The preemption clause provides that "except as provided in [the savings clause] the provisions of this title . . . shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a).

The savings clause provides that "*nothing* in this title shall be construed to exempt or relieve any person from any law of *any* State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A) (emphasis added).

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[1] Nelson received her disability policy in this fashion.

B. Pilot Life

In *Pilot Life Ins. Co. v. Dedeaux*, 486 U.S. 41 (1987), a disabled insured sought to pursue a Mississippi state law claim for tortious breach of contract. This Court found that the Mississippi law was not a law regulating insurance and thus not within the savings clause. It applied a "common sense aproach" and also analyzed the law using the three factors utilized under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et. seq.*, which precludes undue federal influence over state laws which regulate the "business of insurance." Those factors used to determine whether the law regulated the business of insurance are whether the law (1) has the effect of transferring or spreading the policyholder's risk, (2) is integral to the insurer/insured relationship and (3) is limited to the insurance industry.

This Court found that the Mississippi law was not limited to the insurance context but was applicable to all contractual disputes in Mississippi. As such, it did not satisfy the "common sense" approach. This Court also held that the Mississippi law similarly did not satisfy the three McCarran-Ferguson criteria. Therefore, the Court held, the savings clause was inapplicable. *Id.* at 50.

This Court also found that the Mississippi law provided remedies not otherwise available under ERISA. With heavy reliance on the Solictor General, this Court concluded that, in the context of interpreting the savings clause, the civil enforcement remedies of ERISA were to be considered exclusive and to thereby preclude claims such as those under the Mississippi law.

C. The Kanne Case

In *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989), an insured made a claim for damages under California's Insurance Unfair Practices Act codified by

California Insurance Code § 790.03(h)[2]. Arguing that the Insurance Unfair Practices Act was clearly a law regulating insurance, the insureds maintained that claims under that act fell within the savings clause and were thus not preempted.

In *Kanne*, the Ninth Circuit assumed, without deciding, that § 790.03 was a law regulating insurance and thus within the savings clause. However, the court held the statute was still preempted by ERISA. This holding was based entirely on the *Kanne* court's interpretation of *Pilot Life*:

> The Kannes' argument asks us to limit *Pilot Life's* preemption holding to only those state laws which do not fall within the savings clause. To accept this argument, however, we would have to ignore the second half of *Pilot Life* . . . in which the Court made abundantly clear that its preemption holding was equally based on its acceptance of the Solicitor General's view that 'Congress clearly expressed an intent that the civil enforcement provision of ERISA § 502(a) be the exclusive vehicle for [actions] asserting improper processing of a claim for benefits.' *Id.* at 494.

Later Ninth Circuit cases which found bad faith claims —saved or not—preempted by ERISA simply cited *Kanne* and *Pilot Life*. *See e.g., Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1007-08 (9th Cir. 1998); *Par-*

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[2] In 1979, the California Supreme Court authorized a private right of action under this insurance code section in *Royal Globe Ins. Co. v. Superior Court*, 23 Cal.3d 880, 886 (1979). Nine years later it overruled *Royal Globe* and held that no private right of action existed. *Moradi-Shalal v. Fireman's Fund Ins. Co.*, 46 Cal.3d 287 (1988). This left the judicially created tort of the covenant of good fath and fair dealing as the only remaining basis to assert tortious bad faith claims against an insurer. It is this tort which Nelson attempts to assert here.

rino v. FHP, Inc., 146 F.3d 699, 704-05 (9th Cir. 1998); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993). Thus, ever since *Kanne*, the Ninth Circuit has concluded that, regardless of whether a tort claim for insurance bad faith is a law regulating insurance, ERISA permits only one remedy. Accordingly, insurance bad faith claims are always preempted.

D. The Pre-Ward Conflicts: Kanne and Williams

The Second Circuit expressly considered and rejected the Ninth Circuit's erroneous interpretation of *Pilot Life* in *Franklin H. Williams Trust v. Travelers Ins. Co.*, 50 F.3d 144 (2d Cir. 1995). That court considered a claim for violation of a New York law requiring an insurer to pay interest for life insurance benefits beginning at the date of death. The insurer urged that the law was neither saved, as it did not regulate insurance, nor was it consistent with ERISA's exclusive enforcement scheme.

The *Williams* Court interpreted *Pilot Life* as limited to its facts, namely, that only laws which were not within the savings clause were preempted by the enforcement provision. Finding that the law fell within the savings clause, *Williams* disagreed with *Kanne*:

> It also follows that the district court erred in holding that ERISA's civil enforcement provision, § 1132(a)(1)(B), preempts enforcement of the New York law . . . because such a result would be plausible only if the state law itself were also preempted. It would be quixotic to rule that a claim under a state statute that is saved from ERISA preemption . . . may nonetheless be enforced only via ERISA provisions and remedies. *Id.* at 151.

Kanne and *Williams* represent either end of the interpretive spectrum of *Pilot Life*'s exclusive enforcement holding. The Fifth, Seventh, Eighth, Tenth and Eleventh Circuits addressing ERISA preemption after *Pilot Life* have come to ambiguous conclusions. In *Anschultz v.*

Connecticut General Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988), the Eleventh Circuit noted that "[u]nless [the subject state insurance statute] regulates insurance and is thus subject to the ERISA savings caluse of § 514(b)(2)(A), ERISA preempts the state statute." Finding that the statute at issue did not regulate insurance and, thus fell outside the ERISA savings clause, it stated, "[w]e conclude, therefore, that § 624.155 is preempted." *Id.* at 1469. However, the court also rejected the plaintiff's assertion that *Pilot Life* was limited only to common law, as opposed to statutory, claims adding "[w]here otherwise applicable, ERISA preempts all state law. This conclusion is based upon the civil enforcement provisions of ERISA § 502(a)." *Id.*

In *Ramirez v. Inter-Continental Hotels*, 890 F.2d 760 (5th Cir. 1989), the plaintiff sought to assert an unfair insurance practices action under Texas law against his insurer. The court held that the law was one of general application and hence not saved. However the court added that, even if the statute bore a "closer" relationship to the regulation of insurance than the Mississippi law in *Pilot Life* did, "Ramirez, like the plaintiff in *Pilot Life*, seeks to recover, under a state law cause of action, remedies unavailable to him under ERISA. To interpret the savings clause as authorizing such inconsistent state remedies would be to defeat Congressional intent by destroying the exclusivity of ERISA's civil enforcement scheme." *Id.* at 763-64.

Citing *Kanne, supra, Anschultz, supra*, and *In Re Life Ins. Co. N. Am.*, 857 F.2d 1190 (8th Cir. 1988), the court stated, "we thus join three of our sister circuits and numerous district courts in holding that ERISA preempts state statutes that provide a private right of action for the improper handling of insurance claims." *Id.* at 764. *See also, Hansen v. Continental Ins. Co.*, 940 F.2d 971, 979 (5th Cir. 1991) (following *Ramirez*).

In *In Re Life Ins. Co. N. Am.*, 857 F.2d 1190 (8th Cir. 1988), the plaintiff sought to amend his complaint to assert a "vexatious refusal to pay" claim under Missouri statutory law. The court noted that every court to have considered ERISA's preemptive effect over a state vexatious refusal to pay claim found the state statute preempted. *Id.* at 1194. Without doing an analysis of whether the state statute regulated insurance, the court stated, "[t]he Court in *Pilot Life* could not have stated with any greater clarity that the remedies afforded under ERISA are exclusive, and no state law purporting to supply additional remedies will escape the preemptive effective of § 1144(a) as laws 'which regulate insurance' under § 1144(b)(2)(A)." *Id.*

Yet another court, this time the Tenth Circuit, referred to the exclusive civil enforcement provision in declaring an unsaved law preempted. *Gaylor v. John Hancock Mutual Life Insurance Co.*, 112 F.3d 460 (10th Cir. 1997). After finding that the Oklahoma statutory bad faith law was not saved, the court opined that application of the law would run afoul of the enforcement mechanisms of ERISA. The court stated: "we note that in holding that Mississippi's bad faith law was not saved, the *Pilot Life* Court concluded that the civil enforcement provisions of ERISA § 1132(a) were intended to be [exclusive]." *Id.* at 466.

The Seventh Circuit added its interpretation in *DeBruyne v. Equitable Life Assurance Society of the United States*, 920 F.2d 457 (7th Cir. 1990). There, the court found that a New York law which provided a panoply of remedies arising out of an insurer's misrepresentations of the terms of its policy was not a law saved from preemption. While the Seventh Circuit reiterated *Pilot Life's* exclusive remedy discussion, it appeared to do so in the context of determining whether the law in question fell

within the savings clause and not as an independent basis to find preemption. *Id.* at 468, 470.

Thus, the Ninth Circuit has ruled that laws within the savings clause are nonetheless preempted. The Second Circuit holds that such laws are not preempted and the Fifth, Seventh, Eighth, Tenth and Eleventh Circuits have issued opinions which do not clearly answer the question and have been cited for opposite propositions. *Compare Williams, supra,* 50 F.3d at 150, *with Bonestroo v. Continental Life and Acc. Co.,* 79 F.Supp. 1041, 1052 (N.D. Iowa 1999), and *Optimal Health Care Services, Inc. v. Travelers Ins. Co.,* 791 F.Supp. 163, 164 (E.D.Tex. 1992).

Similar state decisions have multiplied since *Pilot Life. See, e.g., Commercial Life Ins. Co. v. Superior Court,* 47 Cal.3d 473, 483 (1988) ("Our reading of *Pilot Life* accords with that of the Ninth Circuit in *Kanne.*"); *Summers v. U.S. Tobacco Co.,* 214 Ill.App.3d 878 (Ill.App. 1991) (Illinois bad faith law preempted based in part on *Pilot Life's* exclusive civil enforcement scheme.); *Curry v. Cincinnati Equitable Ins. Co.,* 834 S.W.2d 701, 707 (Ky.App. 1992); *Smith v. The Guardian Life Ins. Co.,* 546 So.2d 320, 322 (La. App. 1989); *Villascas v. CNA Ins. Companies,* 109 Nev. 1975 (1993); *Cathey v. Metropolitan Life Ins. Co.,* 805 S.W.2d 387 (Tex. 1991); *Cf. Commercial Life Ins. Co. v. Superior Court, supra,* 47 Cal.3d at 489 ("the civil enforcement scheme of [ERISA] does not displace the civil enforcement scheme of the state act: the former concerns the rights of employees under covered plans, the latter the duties of insurers under state laws.") (Mosk, J., dissenting.)

As these opinions demonstrate, the pre-*Ward* interpretations of *Pilot Life* have provided unstable and contradictory guidance to the courts across the country which must rely upon them. It was into this morass that this Court's opinion in *Ward* fell. While seeming to indicate

that most courts have improperly read *Pilot Life* to conclude that the possibility of alternative remedies in ERISA cases was foreclosed forever, *Ward* expressly left unresolved the preemptive status of laws which regulate insurance. This has only worsened the confusion as the decisions since *Ward*, discussed below, attest.

E. Ward Announced that the Feasibility of Alternative Remedies in ERISA Was An Unsettled Question.

In *Ward*, the plaintiff's disability claim was denied by the insurer on the ground that it was untimely. The plaintiff contended that California's notice-prejudice rule, which required the insurer to establish prejudice before denying his claim as untimely, should have applied to his claim. The insurer claimed that the notice-prejudice rule did not fall within ERISA's savings clause. Significantly, the insurer also claimed that, even if the law did fall within the savings clause, it provided a remedy which was in conflict with ERISA's civil enforcement scheme. As such, the insurer claimed, *Pilot Life* meant that it was preempted by ERISA.

In a unanimous opinion written by Justice Ginsburg, this Court rejected the insurer's claims, holding that the law was one which regulated insurance and was therefore within the savings clause. This Court, however, found it unnecessary to address the insurer's second contention that ERISA's remedy provisions were exclusive:

> UNUM next contends that ERISA's civil enforcement provision, § 502(a) . . . preempts any action for plan benefits brought under state rules such as notice-prejudice. Whatever the merits of UNUM's view of § 502(a)'s preemptive force, the issue is not implicated here. Ward sued under § 502(a)(1)(B) 'to recover benefits due . . . under the terms of his plan.' The notice-prejudice rule supplied the relevant rule of decision for this § 502(a) suit. *The*

> *case therefore does not raise the question whether § 502(a) provides the sole launching ground for an ERISA enforcement action. Id.* at 1391 (emphasis added).

This Court then further explained at footnote 7 that *Pilot Life* did not answer this specific question:

> We discussed this issue [of whether a remedy outside ERISA could co-exist with ERISA's remedy provisions] in *Pilot Life* . . . That case concerned Mississippi common law creating a cause of action for bad faith breach of contract, a law not specifically directed to the insurance industry and therefore not saved from ERISA preemption. In that context, the Solicitor General, for the United States as amicus curiae, urged the exclusivity of § 502(a), ERISA's civil enforcement provision . . . In the instant case, the Solicitor General, for the United States as amicus curiae, has endeavored to qualify the argument advanced in *Pilot Life* . . . [T]he Solicitor General now maintains that the discussion of § 502(a) in Pilot Life 'does not in itself require that a state law that "regulates insurance," and so comes within the terms of the savings clause, is nevertheless preempted if it provides a state-law cause of action or remedy.' Brief 25; see also id., at 23 ('[T]he insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated benefits laws.'). We need not address the Solicitor General's current argument, for Ward has sued under § 502(a)(1)(B) for benefits due, and seeks only the application of saved state insurance law as a relevant rule of decision in his § 502(a) action. *Id.* at 1390, n.7.

F. The Post-Ward Conflicts

The above-cited language has increased the confusion among the courts. Some courts have found it significant.

Others have found it unimportant. In *Selby v. Principal Mutual Life Ins. Co.*, 2000 WL 178191 (S.D.N.Y. 2000), the Selbys brought an ERISA action and a claim against their insurer for wrongful denial of health benefits under a New York state law prohibiting policy denials for infertility-related conditions. The insurer conceded that the law fell within the savings clause.

The court rejected the insurer's claim that *Pilot Life* required her state claim be preempted. Citing footnote 7 in *Ward*, *Selby* held that this Court had not resolved the question in *Pilot Life*:

> *Pilot Life*, however, is not on point. Plaintiffs are not suing under a state common law of general application preempted by ERISA; they are suing under a state statute specifically directed towards the insurance industry which defendant concedes is saved from preemption . . . [*Pilot Life*] did not address the distinct question presented here: whether ERISA'S [enforcement provision] preempts a claim based on a state law which regulates insurance within the meaning of ERISA's savings clause. *Id.* at *3.

Ward's footnote 7 was again cited for the same proposition in *Hoffman v. Empire Blue Cross*, 1999 WL 782518 (S.D.N.Y. 1999), "It remains an open question whether ERISA preempts causes of action conferred by state laws that regulate insurance." *Id.* at *7 n. 5.[3]

However, when Nelson made the same arguments accepted in *Selby* and *Hoffman* to the District Court in this case, the court read this Court's language entirely differently: "[T]he court finds *Ward's* footnote 7 to be largely irrelevant to the issues presented by this motion,

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[3] In *Connors v. Maine Medical Center*, 70 F.Supp.2d 40 (D. Me. 1999), the court held that a violation of state law in an ERISA action must be brought separately from the underlying ERISA claim.

and indeed to have little substance at all except as a comment upon the Solicitor General's wavering legal positions. . . . Indeed, reading footnote 7 and then reading Plaintiff's analysis of it, the court wonders if it is reading the same footnote Plaintiff is."[4] App. 6a at n.2.

In the Tenth Circuit, the lower court decisions after *Ward* are now in direct conflict with Tenth Circuit pre-*Ward* precedent. As indicated *supra*, *Gaylor v. John Hancock Mutual Life Insurance Co.*, 112 F.3d 460 (10th Cir. 1997), found that Oklahoma's statutory law of bad faith was not saved. *Id.* at 466. However, subsequent Tenth Circuit district courts have rejected the applicability of *Gaylor* in light of *Ward*.

In *Lewis v. Aetna Life Ins. Co.*, 78 F. Supp. 2d 1202 (N.D. Okla. 1999), the court tracks Nelson's argument in the court below nearly point by point. The *Lewis* court allowed the plaintiff to maintain a state cause of action for bad faith because it was saved under the "recently announced" test in *Ward*. *Id.* at 1204. The court concluded that the Oklahoma law of bad faith, which is nearly identical to that of California[5], regulated insurance "as that phrase has been defined by the United States Supreme Court in [*Ward*]" and was therefore not preempted. *Id.* Remarkably, *Lewis* expressly rejected the applicability of *Gaylor*, holding instead that *Ward* changed the analysis of what laws "regulate insurance" such that pre-*Ward* Tenth Circuit authority holding that

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[4] In *Clancy v. Employers Health Ins. Co.*, 1999 WL 1072540 (E.D. La. 1999), the district court also discussed footnote 7, but found it unhelpful and resorted to prior Fifth Circuit authority.

[5] The bad faith claim in Oklahoma is described and defined in *Christian v. American Home Assurance Co.*, 577 P.2d 899 (Okla. 1977), which expressly based it upon two California precedents, *Fletcher v. W. National Life Insurance Co.*, 10 Cal.App.3d 376 (1970), and *Gruenberg v. Aetna Insurance Co.*, 9 Cal.3d 566 (1973). See discussion in Section III, *supra*.

the Oklahoma law was not within the savings clause was no longer applicable. *Id.* at 1205, n.5, 1214, n.9.

Similarly, on November 1, 1999, Chief United States District Judge of the District of Colorado, Richard E. Matsch allowed an insured to assert a cause of action for insurance bad faith against an insurance company under Colorado law pursuant to this Court's decision in *Ward. Hall v. Unum Life Ins. Co.*, No. 97-M-1828 (D. Co. Nov. 1, 1999). Like the *Lewis* court, Judge Matsch impliedly held that the pre-*Ward* decision of *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 456 (10th Cir. 1989), finding that the Colorado law of insurance bad faith was not exempt from preemption, was no longer applicable.

It is thus plain that there is enormous conflict and confusion between and within the federal circuits and state courts throughout the country over the question presented here. The fissures among and within the circuits continue to grow, creating inconsistency and disparate results in important benefits litigation. This disparity and disunity of federal law is precisely that which Congress attempted to avoid in passing the savings clause as an integral part of ERISA's preemption provisions and the issues presented here are in dire need of prompt resolution by this Court.

II. THE ACCURATE SCOPE OF ERISA'S PREEMPTIVE SWEEP IS OF GREAT PUBLIC IMPORTANCE.

The accurate application of ERISA's preemption clause is of fundamental public importance. As outlined above, since this Court's decision in *Pilot Life*, circuit courts of appeal, including the Ninth Circuit in *Kanne*, and state courts across the country have erroneously extended ERISA preemption to one of the most important state mandated rights upon which many Americans rely: the

right to receive fair and good faith handling of their insurance benefits.

The far-reaching expanse of this preemption does not result in mere economic disputes between parties. It cripples peoples' rights to receive benefits for which they paid and upon which their lives depend. As in the instant matter, disability benefits are particularly vital to workers too hurt to work, because they provide a safety net between insureds and indigence. And as in the instant matter, the misguided application of preemption to laws which are expressly within the savings clause allows insurance companies to flout their obligations to individuals who have paid premiums and to flout the will of Congress when it enacted the worker protection provisions of ERISA. And as in the instant matter, despite the fact that disability benefits were the insured's sole source of income, insurance companies face no punitive or deterring sanction when insurance benefits are denied in bad faith to vulnerable individuals who rely on them. Nor may insurers be found responsible for the sometimes devastating damages which may result from the wrongful denial of such benefits. ERISA did not codify this result, Congress did not intend this result, and *Pilot Life* did not authorize this result. However, as long as the question this Court deemed unsettled remains so, it is vulnerable to overbroad and conflicting interpretations across the country, the most restrictive of which is in Nelson's jurisdiction. Only this Court can answer the question so many insureds are clamoring to have heard.

Nelson's conclusions regarding the staggering effects of the scope of ERISA preemption are widely supported by the outpouring of criticism by respected commentators and members of the bench who have decried the enormous abuses which have arisen in the insurance industry since courts interpreted *Pilot Life* to, in essence, provide insurers with immunity from meaningful penalties for wrongful

and, at times, egregious denials of insurance claims under ERISA.[6]

One particularly powerful description was written by United States District Judge William Young in *Andrews-Clarke v. Travelers Ins. Co.*, 984 F.Supp. 49 (D. Mass. 1997). In that opinion he explains in detail how the "tragic events set forth in [this] complaint cry out for relief." Describing the result which ERISA dictated as "absurd" and "perverse" the Court said:

> ERISA is a 'comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans.' It is therefore deeply troubling that, in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect. What went wrong? *Id.* at 56.

In *Dishman v. UNUM Life Ins. Co.*, 1997 WL 906146 (C.D. Cal), District Judge Letts declared the following with regard to the same defendant which is before this Court:

> [T]he facts of this case are so disturbing that they call into question the merits of the expansive scope of ERISA preemption. [The insurer's] unscrupulous conduct in this action may be closer to the norm of insurance company practice than the court has previously suspected. This case reveals that for benefit plans funded and administered by insurance com-

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[6] *See e.g.*, Stephen S. Ashley, *Did UNUM Life Insurance Co. of America v. Ward Overrule Pilot Life Insurance Co. v. Dedeaux?* BAD FAITH LAW REPORT, vol. XV, No. 9, p. 185. Professor Ashley concludes that the Court did not "overrule" *Pilot Life*, however, he does assert that *Ward* "does cast doubt on the future viability of the comprehensive civil enforcement scheme leg of the *Pilot Life* holding. . . . It is a pity the Court did not use the opportunity in [*Ward*] to speak more directly to the merits of the comprehensive civil enforcement scheme reasoning in *Pilot Life*."

panies, there is no practical or legal deterrent to unscrupulous claims practices. *Id.* at *11-*12.

In *Patrick v. UNUM Life Insurance Co.*, 23 Employee Benefits Cas. 1691, 1696, California Superior Court Judge John G. Schwartz described UNUM's conduct as follows: "This Court must observe that this case is disturbingly similar to *Dishman v. UNUM Life Insurance Co.* [Citation omitted.] Both this case and *Dishman* demonstrate actions by the Defendant which could only be termed bad faith under state law." Judge Schwartz further stated that the court "[is led] to the conclusion that these practices constitute a deliberate corporate policy which has continued despite the condemnation of Dishman." He nonetheless concluded that he was powerless to correct such abuses, stating, "[f]or reasons best known to Congress, ERISA insulates the insurance carriers from financial punishment for even the most egregious conduct." *Id. See also, Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003 (9th Cir. 1998); *Cannon v. Group Health Serv.*, 77 F.3d 1270, 1271 (10th Cir. 1996), *cert. denied*, 519 U.S. 816 (1966).

Further, this petition for certiorari presents the precise argument which the United States Solicitor General presented in *Ward*. Indeed, the position of the Solicitor General is the very position which Nelson urges here which has heretofore been erroneously foreclosed by *Kanne* and other cases.

III. ERISA DOES NOT PREEMPT AN INSURANCE BAD FAITH ACTION IN CALIFORNIA.

The District Court below, as well as the Ninth Circuit, was erroneous not only in the failure to recognize the conflict presented by *Ward* regarding the availability of alternative remedies for benefits violations, but also in finding that California's tort of insurance bad faith was not a law regulating insurance. State law authorities

clearly establish that California's law is one which regulates insurance. Because state law precedents, particularly in light of the clarification of the "common sense" and McCarran-Ferguson tests articulated in *Ward*, establish that the California law meets the test as one falling within ERISA's savings clause, this Court should find that it is not preempted.

A. California's Insurance Bad Faith Law Fails Within the Savings Clause.

A tort cause of action for insurance bad faith is a judicially created claim which is well established in California law. *Foley v. Interactive Data Corporation*, 47 Cal.3d 654 (1988); *Egan v. Mutual of Omaha Ins. Co.*, Cal.3d 809 (1979), *cert. denied*, 445 U.S. 912 (1980); *Gruenberg v. Aetna Ins. Co.*, 9 Cal.3d 566 (1973); *Crisci v. Security Ins. Co.*, 66 Cal.3d 425 (1967). The tort arose out of public policy concerns reflecting the importance of insurance in our society and the need for the protection of vulnerable insureds against absusive actions by far more powerful insurers.[7] In *Foley, supra*, 47 Cal.3d at 684, the California Supreme Court explained the public policy considerations which underlie the tort of insurance bad faith. It also made clear that this tortious remedy is limited solely and exclusively to insurance claims:

> An exception to [the] general rule [limiting compensation for breach of the implied covenant to contract remedies] has developed in the context of insurance contracts where, for a variety of policy reasons, courts have held that breach of the implied covenant will provide the basis for an action in tort.

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[7] This case serves as a perfect example of this abuse. Notwithstanding Nelson's catastrophic injuries and her obvious, meticulously documented disability, UNUM (believing it had immunity from unconscionable claims decisions) claims that it was entitled to terminate Nelson's sole source of income because she did not respond to one of its letters in a timely fashion.

California has a well-developed judicial history addressing this exception.

Similarly, in *Egan v. Mutual of Omaha Ins. Co., supra,* 24 Cal.3d at 819, the court described the rationale behind excepting insurance bad faith actions from the usual prohibition for tort remedies, specifying several factors unique to the insurance industry. Notably, the court said that an insured does not seek to gain an *advantage* in purchasing insurance, but "rather, he seeks protection against calamity." *Id.* The Egan court noted the "quasi-public" nature of the service offered by insurers, requiring insurers to prioritize the interests of the public over their own interest in lowering disbursements. *Id.* at 820. Finally, the *Egan* court emphasized that "the relationship of insurer and insured is inherently unbalanced: the adhesive nature of insurance contracts places the insurer in a superior bargaining position." *Id.* These considerations led the California Supreme Court to conclude that "[t]he special relationship between the insurer and the insured illustrates the public policy considerations that may support exemplary damages in cases such as this." *Id.*

These principles were recently reaffirmed in *Cates Construction Inc. v. Talbot Partners,* 86 Cal.Rptr.2d 855 (1999). *Cates* held that "[a]t present, this court recognizes only one exception to that general rule [that compensation for breach of the implied covenant of good faith and fair dealing is limited to contract rather than tort remedies]: tort remedies are available for a breach of the covenant in cases involving insurance policies." *Id.* at 865.

The analysis of whether California insurance bad faith law is saved from ERISA's preemptive ambit mirrors that performed by the *Ward* Court in interpreting the notice-prejudice rule. The *Ward* Court explained that California's notice-prejudice rule (like bad faith) is "grounded in policy concerns specific to the insurance industry. . . .

The grounding is the key to our decision." *Ward, supra,* 119 S.Ct. at 1388. A long line of California cases exemplified by *Foley, Egan* and *Cates* demonstrate that California's insurance bad faith law satisfies the definition in *Ward.* With respect to the "common-sense" test, the cause of action for insurance bad faith is grounded in policy concerns specific to the insurance industry in the exact same manner as the notice-prejudice rule. *Foley, supra,* 47 Cal.3d at 684; *Cates, supra,* 21 Cal.4th at 45.

California's insurance bad faith law also satisfies the McCarran-Ferguson three-factor analysis in precisely the same way that the notice-prejudice rule does. Insurance bad faith claims affect the first factor, risk spreading—which the *Ward* Court did not even consider—no less than the notice-prejudice rule. Indeed, insurers regularly argue that permitting insurance bad faith claims will increase the payments required of them and accordingly the premiums charged. As for the remaining factors, the implied covenant of good faith and fair dealing could not be more integral to the relationship between the insured and the insurer because it pervades the entire claims process. Indeed, it applies to all insurance claims, whereas the notice-prejudice rule only applies to a very small percentage of claims. While the notice-prejudice rule requires the insurer to prove actual prejudice before denying a claim as untimely, the covenant of good faith and fair dealing requires much more:

> For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement, it . . . must give at least as much consideration to the [insured's] interest as it does to its own . . . [I]t is essential that an insurer fully inquire into possible bases that might support the insured's claim . . . [A]n insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial. *Egan, supra,* 24 Cal.3d at 818-19.

Finally, there is no question that under *Foley*, *Egan* and *Cates*, insurance bad faith claims are limited to the insurance industry. Again, the insurance bad faith law "does not merely have an impact on the insurance industry, it is aimed at it." *Ward, supra*, 119 S.Ct. at 1390.[8]

B. ERISA Does Not Provide the Sole Remedy for Claims of Unlawful Insurance Practices and Does Not Preempt Laws Which "Regulate Insurance" as Does California's Insurance Bad Faith Law.

ERISA provides that "*nothing* in [ERISA] shall be construed to exempt or relieve *any* person from *any* law of any State which regulates insurance." 29 U.S.C. § 1144 (emphasis added). The result in *Kanne* and similar decisions effectively eviscerates the savings clause. While the substantive state law may be expressly saved from exemption under the language of ERISA, the exemption is effectively meaningless as a violation of the state law cannot be enforced or remedied under *Kanne's* erroneous and overbroad interpretation of the second half of *Pilot Life*.

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[8] The Court below erroneously found that the third McCarran-Ferguson factor requiring a saved law to be aimed exclusively at the insurance industry was not met because "courts have consistently acknowledged that there is room, even if exceedingly small, for this doctrine in other contexts which simply have not yet come before the courts." App. 4a. Yet, the tort of bad faith has been in existence now for over 30 years. *See Gruenberg, supra*, 9 Cal.3d at 573. To find that the third McCarran-Ferguson guideline is not met because there is some theoretical room for its application, however miniscule, outside the insurance context, simply does not comport with the standard for weighing the factors. As the Court made clear in *Ward*, evaluation of the McCarran-Ferguson factors are only "checking points or 'guideposts', not separate essential elements . . . that must be satisfied." *Id.* at 1389.

Moreover, the Court below also acknowledged that it "would tend to agree that a covenant requiring that the parties act in good faith would be integral to the relationship but it feels bound by the Ninth Circuit's holding in *Kanne* that bad faith law does not 'concern the policy relationhip'." App. 5a at n.1. Unfortunately, *Kanne* did not make such a finding.

As the primary source of insurance for many Americans, workplace benefits enforceable by laws which regulate insurance were expressly set aside from ERISA's preemptive scope. To deny these insureds the right to pursue the violation of those saved laws deprives them of the effective protection for which insurance was established, and denies the states the ability to protect their citizens from these potentially devastating breaches.

This is not what Congress intended. As this Court recognized in *Ward*, the discussion in *Pilot Life* regarding the exclusivity of ERISA's remedies was made in the context of interpreting the savings clause. "Because in this case, the state cause of action seeks remedies for the improper processing of a claim for benefits under an ERISA-regulated plan, *our understanding of the saving clause* must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)." *Pilot Life, supra*, 481 U.S. at 1555 (emphasis added).

The Solicitor General, upon whom this Court places great reliance, urged in his brief in *Ward* that state laws providing remedies which are an alternative to ERISA's remedies not only may co-exist with each other but, in fact, were intended to by Congress. The Government's brief in *Ward* indicated that ERISA does preempt "generally applicable state-law remedies" relating to ERISA plans. It continued to underscore that "[i]t does not follow, however, that ERISA Section 502 should inform the inquiry to the same extent with respect to a state-law cause of action or remedy that specifically 'regulates insurance' as it does with respect to one of general applicability." 1998 WL 839957, at *21-*22.

The Solicitor General questioned why Congress would have carefully exempted substantive state law, and then foreclosed access to state enforcement mechanisms to

remedy those substantive state law violations. The brief further explained:

> . . . Congress has saved state substantive law, and it is not clear why Congress would have wanted to foreclose all access to state-created remedies or sanctions to enforce that substantive law . . . [T]he savings clause by its terms directs that nothing in Section 502, which concerns causes of action and remedies under ERISA shall be 'construed' to relieve or exempt any person from 'any law' of a State that regulates insurance. Thus, the insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated-benefit laws and other prescriptive measures that do so. *Id.* at *22-*23.

Clearly, the savings clause and the civil enforcement provision may be interpreted harmoniously under the limited holding in *Pilot Life*. This conclusion is bolstered by this Court's recent "reverse preemption" decision in *Humana Inc. v. Forsyth et al.*, 119 S.Ct. 710 (1999). There, the petitioner sought to assert a federal claim against an insurance company under RICO alleging a pattern of racketeering activity. The insurer moved to dismiss the RICO claim on the ground that it was precluded by the McCarran-Ferguson Act, which prohibits the application of federal statutes which would "invalidate, impair or supersede" state laws regulating the business of insurance. The insurer claimed that, because RICO provided for remedies unavailable under state law, this "impaired" the state's insurance laws and thus was prohibited.

This Court concluded that RICO claims were not precluded by the McCarran-Ferguson Act. It specifically found that "a federal law which proscribes the same conduct as state law, but provides materially different remedies [does not] 'impair' state law under . . . McCarran-

Ferguson." *Id.* at 715. Just as the federal RICO remedies do not impair the states' insurance laws, the states' insurance remedies do not impair the federal ERISA law. This is particularly so given that ERISA specifically contemplates that state insurance laws will be permitted to remain outside ERISA and that "nothing" in ERISA will affect "any" of those laws.

In addition, previous Supreme Court cases foreshadowed and further support this analysis. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Court held that a state law mandating insurance benefits was a law which regulated the business of insurance and was saved from preemption by ERISA's savings clause. See also, *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

In *California Division of Labor Standards Enforcement v. Dillingham Construction N.A., Inc.*, 519 U.S. 316 (1997), the Court held that a state law neither made "reference to" nor had "connection with" ERISA plans and therefore did not "relate to" ERISA plans and was not preempted. The concurring opinion by Justices Scalia and Ginsburg observed that the ERISA preemption criteria set forth in some of the court's earlier cases, including *Pilot Life*, have "in effect been abandoned" as "a project doomed to failure". *Id.* at 335 (Scalia, J., concurring).

FMC Corp. v. Holliday, 498 U.S. 52 (1990), has been interpreted to stand for the proposition that Congress, by treating insured plans differently than uninsured plans, the latter not being deemed the business of insurance, intended that ERISA reserve to the states the direct regulation of insurers as well as the substantive terms of insurance contracts. *See, International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 401 (6th Cir. 1992).

Unquestionably, ERISA, a law primarily intended to protect employees, was not intended to wreak harm on its beneficiaries. Indeed, Nelson asserts that the actions of the insurer before this Court, and in innumerable similar circumstances, are a reflection of what happens when a powerful insurer obtains immunity from suit under state law regulating insurance by a vulnerable citizen whose life and well-being has been entrusted to it. Such conduct is subject to state laws regulating insurance, not ERISA.

Certainly, this is the very concern that led Congress, consistent with the McCarran-Ferguson Act, to include the savings clause within ERISA, thereby permitting states to assure the proper handling of insurance claims through the application of appropriate remedial state insurance laws.

CONCLUSION

For the foregoing reasons, Nelson respectfully urges the Court to grant a writ of certiorari in this case.

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	29 U.S.C. § 1002	13a
	29 U.S.C. § 1132	33a
	29 U.S.C. § 1144	43a
	Cal. Bus. & Prof. Code § 17200	48a
	Cal. Ins. Code § 790.03(h)	49a

APPENDIX A

[Filed Dec. 20, 1999]

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 99-71367

IN RE: KRIS NELSON

KRIS NELSON,
Petitioner,

v.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA,
Respondent,

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Real Party in Interest.

DC# CV-96-20974-WAI
Northern California (San Jose)

ORDER

Before: LEAVY, TROTT and SILVERMAN, Circuit Judges.

Petitioner has not demonstrated that this case warrants the intervention of this court by means of the extraordinary remedy of mandamus. *See Bauman v. United States District Court,* 557 F.2d 650 (9th Cir. 1977). Accordingly, the petition is denied.

APPENDIX B

[Filed Sep. 22, 1999]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C-96-20974 WAI

KRIS NELSON,

Plaintiff,

v.

UNUM LIFE INSURANCE CO.,

Defendant.

ORDER GRANTING IN PART AND DENYING IN PART PLAINTIFF'S MOTION TO AMEND AND DENYING THE REQUEST FOR INTERLOCUTORY CERTIFICATION

Plaintiff moves for leave to amend her ERISA complaint to allege a claim for breach of the covenant of good faith and fair dealing (bad faith) on the authority of the Supreme Court's recent opinion in *UNUM Life Ins. Co. v. Ward*, 526 U.S. ——, 119 S.Ct. 1380 (April 20, 1999). She also seeks to add a claim for trespass.

For the reasons set out below, the court hereby DENIES leave to add a bad faith claim and GRANTS leave to add a trespass claim.

DISCUSSION

I. Bad Faith

A. The *Ward* Case

Ward found that California's notice-prejudice rule is a law regulating insurance and thus is saved from preemption under ERISA's section 514(a) (29 U.S.C. § 1144 (a)). *See also* 29 U.S.C. § 1144(b)(2)(A). Plaintiff argues that this decision represents a major retreat from the Court's opinion in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987), in which the Court held that Mississippi's bad faith law was a law "relating to" an employee benefit plan and was not saved because it did not "home in" on the insurance industry. *See Ward,* 119 S.Ct. at 1387; *Pilot Life,* 481 U.S. at 50.

Despite Plaintiff's characterizations, this court finds that *Ward* does not change the analysis set forth by the Court in *Pilot Life.* In fact, *Ward* itself employs this analysis to reach its conclusion regarding the notice-prejudice law. Application of the analysis to California's bad faith law compels the conclusion, previously reached by the Ninth Circuit in *Kanne v. Connecticut Gen. Life Ins. Co.* 867 F.2d 489 (9th Cir. 1989), that the common law right of action is not "specifically directed toward the [insurance] industry." *Kanne,* 867 F.2d at 494, *citing Pilot Life,* 481 U.S. at 50.

Specifically, this court finds that California's bad faith law is a law which "relates to" an employee benefit plan. Plaintiff does not dispute this point. Therefore, she can invoke the benefits of this law only if it is a law which "regulates insurance."

As the Court noted in *Ward,*

> Our precedent provides a framework for resolving whether a state law 'regulates insurance' within the

> meaning of the saving clause. First, we ask whether, from a 'common-sense view of the matter,' the contested prescription regulates insurance. Second, we consider three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act: 'first, whether the practice has the effect of transferring or spreading a policy holder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.'

Ward, 119 S.Ct. at 1386. The Court then used this framework to hold that the notice-prejudice rule was a law regulating insurance, finding that the law met all the criteria with the possible exception of the risk spreading factor (but noting that the McCarran-Ferguson factors were only "considerations" and not requirements). *Id.* at 1386-87, 1389-90.

Applying this framework to California's common law of insurance bad faith must reach a different result, however. The distinction turns on the Supreme Court's emphasis on the manner in which the subject law is "focused on," "directed at" and "homes in on" the insurance industry. The notice-prejudice law is "a rule mandatory for insurance contracts, not a principle a court may pliably employ when the circumstances so warrant." *Id.* at 1388.

On this point, Plaintiff makes much of the fact that California courts have restricted bad faith principles to the insurance context but the truth is that courts have consistently acknowledged that there is room, even if exceedingly small, for this doctrine in other contexts which simply have not yet come before the courts. *See Foley v. Interactive Data Corp.*, 47 Cal. 3d 654, 682-701 (1988)

and cases cited therein. Even Plaintiff's post-hearing citation to *Cates Construction, Inc. v. Talbot Partners,* 21 Cal. 4th 28, 1999 D.A.R. 7725 (July 29, 1999), supports this interpretation, stating "*At present,* the court recognizes only one exception to that general rule [barring tort remedies for breach of the covenant]." *Cates Construction,* 1999 D.A.R. at 7728 (emphasis supplied).

This court concludes that under *Ward,* California's bad faith law is preempted by ERISA because it is clearly "related" to an employee benefit plan and it is not saved from preemption because it does not "regulate insurance" under either the common sense/*Pilot Life* definition (because it does not "home in on" the insurance industry) or the McCarran-Ferguson factors (because it does not "spread the risk," "focus on the insurance industry," nor is it "integral to the policy relationship").[1]

B. *Humana, Inc. v. Forsyth*

Plaintiff argues that *Ward* creates a right to seek remedies outside the scope of ERISA and cites *Humana, Inc. v. Forsyth,* 525 U.S. 299, 119 S.Ct. 710 (Jan. 20, 1999), for its holding that plaintiffs could pursue a federal RICO action against their health insurer despite the McCarran-Ferguson Act's prohibition against the enforcement of federal laws which impair state insurance regulations. While RICO provides for treble damages, state law permitted only compensatory and punitive damages. The Supreme Court held, however, that RICO's private right of action did not frustrate the state's statutory and

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1 On this last isssue, the court would tend to agree that a covenant requiring that the parties act in good faith would be integral to the relationship but it feels bound by the Ninth Circuit's holding in *Kanne* that bad faith law does not "concern the policy relationship." *Kanne,* 867 F.2d at 494. In any event, it is of no import since the presence of one McCarran-Ferguson factor in the absence of the others would not define a law as one regulating insurance.

common-law claims for relief but rather complemented them. *Id.* at 119 S.Ct. 719.

Plaintiff contends that *Humana* represents the "flip-side" of *Ward* and that under its reasoning federal laws would not preempt state remedies which are not in direct conflict with the federal scheme. The problem with this analysis, however, is that courts have consistently interpreted ERISA's text and legislative history as manifesting a Congressional intent to occupy the field of employee benefit plan administration. *See, e.g., Pilot Life,* 481 U.S. at 52-56; *Kanne,* 867 F.2d at 494, *Ward,* 119 S.Ct. at 1391, fn. 7.[2]

Ward does not depart from this decisional line. Rather, it recalls and approves *Pilot Life*'s holding that ERISA displaces state causes of action. *Ward,* 119 S.Ct. at 1391, fn. 7; *Pilot Life,* 481 U.S. at 57. There, the plaintiff had brought a claim under ERISA for benefits due and the court found that California's notice-prejudice rule pro-

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[2] Although the court finds *Ward*'s footnote 7 to be largely irrelevant to the issues presented by this motion, and indeed to have little substance at all except as a comment upon the Solicitor General's wavering legal positions, the court feels it must address it since Plaintiff places such heavy reliance upon it. The footnote merely points out that *Pilot Life* decided the question of "whether § 502(a) provides the sole launching ground for an ERISA enforcement action" in the affirmative and states that any elaboration or narrowing of that holding need not be addressed under *Ward*'s facts because he in fact brought suit under § 502(a). Thus, footnote 7 does not go "out of its way" to disapprove *Kanne*'s holding that ERISA prohibits alternative state remedies (*Kanne,* 867 F.2d at 494) nor does it "obviously . . . make clear" that *Kanne* and like decisions misread *Pilot Life.* Mo. for Leave to Amend, pp. 13, 15. Plaintiff states that "[i]f the Supreme Court believed that *Kanne* had correctly stated the law, . . . [it] would simply have stated that the issue of whether a state remedy could co-exist with ERISA had been decided in *Pilot Life.*" *Id.* at 15. In fact, this is exactly what it did state in footnote 7. Indeed, reading footnote 7 and then reading Plaintiff's analysis of it, the court wonders if it is reading the same footnote Plaintiff is.

vided a relevant rule of decision for purposes of evaluating that claim. *Ward,* 119 S.Ct. at 1391. Unlike the law of insurance bad faith, the notice-prejudice law does not provide its own right of action or its own remedial scheme.

II. Trespass

For the reasons which it permitted the allegation of a claim of Invasion of Privacy, the court shall permit Plaintiff to amend her complaint to state a claim for Trespass as well. The Amended Complaint must not differ in any other respect from the currently operative Complaint and shall be filed on or before October 4, 1999.

III. Interlocutory Review

The court finds that the standard for certification of the issues addressed herein has not been met in that there is not substantial ground for a difference of opinion on the question of whether Plaintiff can allege a bad faith cause of action against her ERISA plan and that, while such ground may exist on the issue of the propriety of the other tort claims which the court has allowed, interruption of the litigation at this stage to appeal these secondary issues would not be efficient use of judicial resources. The request under 28 U.S.C. § 1292(b) is therefore denied.

Dated: 9-20-99

/s/ William A. Ingram
WILLIAM A. INGRAM
United States District Judge

APPENDIX C

STATUTORY PROVISIONS

15 U.S.C.A. § 1011

UNITED STATES CODE ANNOTATED
TITLE 15. COMMERCE AND TRADE
CHAPTER 20—REGULATION OF INSURANCE

§ 1011. Declaration of policy

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

28 U.S.C.A. § 1254

UNITED STATES CODE ANNOTATED
TITLE 28.
JUDICIARY AND JUDICIAL PROCEDURE
PART IV—JURISDICTION AND VENUE
CHAPTER 81—SUPREME COURT

§ 1254. Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

(2) By certification at any time by a court of appeals of any question of law in any civil or criminal case as to which instructions are desired, and upon such certification the Supreme Court may give binding instructions or require the entire record to be sent up for decision of the entire matter in controversy.

29 U.S.C.A. § 1001

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE A—GENERAL PROVISIONS

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the es-

tablishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries.

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protecting of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance.

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

29 U.S.C.A. § 1002

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I—PROTECTION OF EMPLOYEE BENEFITS RIGHTS
SUBTITLE A—GENERAL PROVISIONS

§ 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise. (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this chapter providing one or more exempt categories under which—

(i) severance pay arrangements, and

(ii) supplemental retirement income payments, under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of Labor) since retirement,

shall, for purposes of this subchapter, be treated as welfare plans rather than pension plans. In the case of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this chapter applicable to pension plans, such arrangement or payment shall be treated as a pension plan.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of deal-

ing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Con-

tinental Shelf lands defined in the Outer Continental Shelf Lands Act (43 U.S.C. 1331-1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the meaning of the Labor Management Relations Act, 1947 [29 U.S.C.A. § 141 et seq.], or the Railway Labor Act [45 U.S.C.A. § 151 et seq.]

(13) The term "Secretary" means the Secretary of Labor.

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation.[1]

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[1] So in original. The period probably should be a comma.

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise,

which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation.

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate,

is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D) or (E);

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E) or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

The Secretary, after consultation and coordination with the Secretary of the Treasury, may by regulation prescribe a percentage lower than 50 percent for subparagraph

(E) and (G) and lower than 10 percent for subparagraph (H) or (I). The Secretary may prescribe regulations for determining the ownership (direct or indirect) of profits and beneficial interests, and the manner in which indirect stockholdings are taken into account. Any person who is a party in interest with respect to a plan to which a trust described in section 501(c)(22) of Title 26 is permitted to make payments under section 1403 of this title shall be treated as a party in interest with respect to such trust.

(15) The term "relative" means a spouse, ancestor, lineal descendant, or spouse of a lineal descendant.

(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

(17) The term "separate account" means an account established or maintained by an insurance company under

which income, gains, and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company.

(18) The term "adequate consideration" when used in part 4 of subtitle B of this subchapter means (A) in the case of a security for which there is a generally recognized market, either (i) the price of the security prevailing on a national securities exchange which is registered under section 78f of Title 15, or (ii) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of any party in interest; and (B) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with regulations promulgated by the Secretary.

(19) The term "nonforfeitable" when used with respect to a pension benefit or right means a claim obtained by a participant or his beneficiary to that part of an immediate or deferred benefit under a pension plan which arises from the participant's service, which is unconditional, and which is legally enforceable against the plan. For purposes of this paragraph, a right to an accrued benefit derived from employer contributions shall not be treated as forfeitable merely because the plan contains a provision described in section 1053(a)(3) of this title.

(20) The term "security" has the same meaning as such term has under section 77b(1) of Title 15.

(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

(B) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940 [15 U.S.C.A. § 80a-1 et seq.], such investment shall not by itself cause such investment company or such investment company's investment adviser or principal underwriter to be deemed to be a fiduciary or a party in interest as those terms are defined in this subchapter, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

(22) The term "normal retirement benefit" means the greater of the early retirement benefit under the plan, or the benefit under the plan commencing at normal retirement age. The normal retirement benefit shall be determined without regard to—

(A) medical benefits, and

(B) disability benefits not in excess of the qualified disability benefit.

For purposes of this paragraph, a qualified disability benefit is a disability benefit provided by a plan which does not exceed the benefit which would be provided for the participant if he separated from the service at normal retirement age. For purposes of this paragraph, the early retirement benefit under a plan shall be determined without regard to any benefit under the plan which the Secretary of the Treasury finds to be a benefit described in section 1054(b)(1)(G) of this title.

(23) The term "accrued benefit" means—

(A) in the case of a defined benefit plan, the individual's accrued benefit determined under the plan and, except as provided in section 1054(c)(3) of this title, expressed in the form of an annual benefit commencing at normal retirement age, or

(B) in the case of a plan which is an individual account plan, the balance of the individual's account.

The accrued benefit of an employee shall not be less than the amount determined under section 1054(c)(2)(B) of this title with respect to the employee's accumulated contribution.

(24) The term "normal retirement age" means the earlier of—

(A) the time a plan participant attains normal retirement age under the plan, or

(B) the later of—

(i) the time a plan participant attains age 65, or

(ii) the 5th anniversary of the time a plan participant commenced participation in the plan.

(25) The term "vested liabilities" means the present value of the immediate or deferred benefits available at normal retirement age for participants and their beneficiaries which are nonforfeitable.

(26) The term "current value" means fair market value where available and otherwise the fair value as determined in good faith by a trustee or a named fiduciary (as defined in section 1102(a)(2) of this title) pursuant to the terms of the plan and in accordance with regulations of the Secretary, assuming an orderly liquidation at the time of such determination.

(27) The term "present value," with respect to a liability, means the value adjusted to reflect anticipated events. Such adjustments shall conform to such regulations as the Secretary of the Treasury may prescribe.

(28) The term "normal service cost" or "normal cost" means the annual cost of future pension benefits and administrative expenses assigned, under an actuarial cost method, to years subsequent to a particular valuation date of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(29) The term "accrued liability" means the excess of the present value, as of a particular valuation date of a pension plan, of the projected future benefit costs and administrative expenses for all plan participants and beneficaries over the present value of future contributions for the normal cost of all applicable plan participants and beneficiaries. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(30) The term "unfunded accrued liability" means the excess of the accrued liability, under an actuarial cost

method which so provides, over the present value of the assets of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(31) The term "advance funding actuarial cost method" or "actuarial cost method" means a recognized actuarial technique utilized for establishing the amount and incidence of the annual actuarial cost of pension plan benefits and expenses. Acceptable actuarial cost methods shall include the accrued benefit cost method (unit credit method), the entry age normal cost method, the individual level premium cost method, the aggregate cost method, the attained age normal cost method, and the frozen initial liability cost method. The terminal funding cost method and the current funding (pay-as-you-go) cost method are not acceptable actuarial cost methods. The Secretary of the Treasury shall issue regulations to further define acceptable actuarial cost methods.

(32) The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the Railroad Retirement Act of 1935, or 1937 [45 U.S.C.A. § 231 et seq.] applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act [22 U.S.C.A. § 288 et seq.].

(33)(A) The term "church plan" means a plan established and maintained (to the extent required in clause (ii) of subparagraph (B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of Title 26.

(B) The term "church plan" does not include a plan—

(i) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513 of Title 26), or

(ii) if less than substantially all of the individuals included in the plan are individuals described in subparagraph (A) or in clause (ii) of subparagraph (C) (or their beneficiaries).

(C) For purposes of this paragraph—

(i) A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(ii) The term employee of a church or a convention or association of churches includes—

(I) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of his compensation;

(II) an employee of an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of Title 26 and which is controlled by or associated with a church or a convention or association of churches; and

(III) an individual described in clause (v).

(iii) A church or a convention or association of churches which is exempt from tax under section 501 of Title 26 shall be deemed the employer of any individual included as an employee under clause (ii).

(iv) An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(v) If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of Title 26 and which is controlled by or associated with a church or a convention or association of churches, the church plan shall not fail to meet the requirements of this paragraph merely because the plan—

(I) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(II) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within the meaning of section 72(m)(7) of Title 26) at the time of such separation from service.

(D)(i) If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of Title 26 fails to meet one

or more of the requirements of this paragraph and corrects its failure to meet such requirements within the correction period, the plan shall be deemed to meet the requirements of this paragraph for the year in which the correction was made and for all prior years.

(ii) If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this paragraph beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(iii) For purposes of this subparagraph, the term "correction period" means—

(I) the period ending 270 days after the date of mailing by the Secretary of the Treasury of a notice of default with respect to the plan's failure to meet one or more of the requirements of this paragraph; or

(II) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements, or, if the court does not specify such period, any reasonable period determined by the Secretary of the Treasury on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(III) any additional period which the Secretary of the Treasury determines is reasonable or necessary for the correction of the default,

whichever has the latest ending date.

(34) The term "individual account plan" or "defined contribution plan" means a pension plan which provides for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other par-

ticipants which may be allocated to such participant's account.

(35) The term "defined benefit plan" means a pension plan other than an individual account plan; except that a pension plan which is not an individual account plan and which provides a benefit derived from employer contributions which is based partly on the balance of the separate account of a participant—

(A) for the purposes of section 1052 of this title, shall be treated as an individual account plan, and

(B) for the purposes of paragraph (23) of this section and section 1054 of this title, shall be treated as an individual account plan to the extent benefits are based upon the separate account of a participant and as a defined benefit plan with respect to the remaining portion of benefits under the plan.

(36) The term "excess benefit plan" means a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415 of Title 26 on plans to which that section applies without regard to whether the plan is funded. To the extent that a separable part of a plan (as determined by the Secretary of Labor) maintained by an employer is maintained for such purpose, that part shall be treated as a separate plan which is an excess benefit plan.

(37)(A) The term "multiemployer plan" means a plan—

(i) to which more than one employer is required to contribute,

(ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation.

(B) For purposes of this paragraph, all trades or businesses (whether or not incorporated) which are under common control within the meaning of section 1301(b)(1) of this title are considered a single employer.

(C) Notwithstanding subparagraph (A), a plan is a multiemployer plan on and after its termination date if the plan was a multiemployer plan under this paragraph for the plan year preceding its termination date.

(D) For purposes of this subchapter, notwithstanding the preceding provisions of this paragraph, for any plan year which began before September 26, 1980, the term "multiemployer plan" means a plan described in this paragraph (37) as in effect immediately before such date.

(E) Within one year after September 26, 1980, a multiemployer plan may irrevocably elect, pursuant to procedures established by the corporation and subject to the provisions of sections 1453(b) and (c) of this title, that the plan shall not be treated as a multiemployer plan for all purposes under this chapter or the Internal Revenue Code of 1954 if for each of the last 3 plan years ending prior to the effective date of the Multiemployer Pension Plan Amendments Act of 1980—

(i) the plan was not a multiemployer plan because the plan was not a plan described in subparagraph (A)(iii) of this paragraph and section 414(f)(1)(C) of Title 26 (as such provisions were in effect on the day before September 26, 1980); and

(ii) the plan had been identified as a plan that was not a multiemployer plan in substantially all its filings with the corporation, the Secretary of Labor and the Secretary of the Treasury.

(F)(i) For purposes of this subchapter a qualified football coaches plan—

(I) shall be treated as a multiemployer plan to the extent not inconsistent with the purposes of this subparagraph; and

(II) notwithstanding section 401(k)(4)(B) of Title 26, may include a qualified cash and deferred arrangement.

(ii) For purposes of this subparagraph, the term "qualified football coaches plan" means any defined contribution plan which is established and maintained by an organization—

(I) which is described in section 501(c) of Title 26;

(II) the membership of which consists entirely of individuals who primarily coach football as full-time employees of 4-year colleges or universities described in section 170(b)(1)(A)(ii) of Title 26; and

(III) which was in existence on September 18, 1986.

(38) The term "investment manager" means any fiduciary (other than a trustee or named fiduciary, as defined in section 1102(a)(2) of this title)—

(A) who has the power to manage, acquire, or dispose of any asset of a plan;

(B) who (i) is registered as an investment adviser under the Investment Advisers Act of 1940 [15 U.S.C.A. § 80b-1 et seq.]; (ii) is not registered as an investment adviser under such Act by reason of paragraph (1) of section 80b-3a of Title 15, is registered as an investment adviser under the laws of the State (referred to in such paragraph (1)) in which it maintains its principal office and place of business, and, at the time the fiduciary last

filed the registration form most recently filed by the fiduciary with such State in order to maintain the fiduciary's registration under the laws of such State, also filed a copy of such form with the Secretary; (iii) is a bank, as defined in that Act; or (iv) is an insurance company qualified to perform services described in subparagraph (A) under the laws of more than one State; and

(C) has acknowledged in writing that he is a fiduciary with respect to the plan.

(39) The terms "plan year" and "fiscal year of the plan" mean, with respect to a plan, the calendar, policy, or fiscal year on which the records of the plan are kept.

(40)(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

(ii) by a rural electric cooperative, or

(iii) by a rural telephone cooperative asociation.

(B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

(ii) the term "control group" means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 1301(b) of this title, except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent,

(iv) the term "rural electric cooperative" means—

(I) any organization which is exempt from tax under section 501(a) of Title 26 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of section 501(c) of Title 26 which is exempt from tax under section 501(a) of Title 26 and at least 80 percent of the members of which are organizations described in subclause (I), and

(v) the term "rural telephone cooperative association" means an organization described in paragraph (4) or (6) of section 501(c) of Title 26 which is exempt from tax under section 501(a) of such Title and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

(41) [2] Single-employer plan

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[2] So in original. Two pars. (41) have been enacted.

The term "single-employer plan" means an employee benefit plan other than a multiemployer plan.

(41) [2] The term "single employer plan" means a plan which is not a multiemployer plan.

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[2] So in original. Two pars. (41) have been enacted.

29 U.S.C.A. § 1132

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18—EMPLOYEE RETIREMENT
INCOME SECURITY PROGRAM
SUBCHAPTER I—PROTECTION OF
EMPLOYEE BENEFIT RIGHTS
SUBTITLE B—REGULATORY PROVISIONS
PART 5—ADMINISTRATION AND ENFORCEMENT

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169 (a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [1] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

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[1] So in original. Probably should be "subtitle".

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 1191b(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's dis-

cretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his

capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or

the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975 (f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

29 U.S.C.A. § 1144

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I—PROTECTION OF EMPLOYEE BENEFITS RIGHTS
SUBTITLE B—REGULATORY PROVISIONS
PART 5—ADMINISTRATION AND ENFORCEMENT

§ 1144. Other laws.

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor

any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to

assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42

U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in section 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

CAL. BUS. & PROF. CODE § 17200

§ 17200. Unfair competition; prohibited activities

As used in this chapter, unfair competition shall mean and include any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with Section 17500) of Part 3 of Division 7 of the Business and Professions Code.

(Added by Stats.1977, c. 299, p. 1202, § 1. Amended by Stats.1992, c. 430 (S.B.1586), § 2.)

CAL. INS. CODE § 790.03(h)

§ 790.03 Unfair Trade Practices Defined

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

* * * *

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable man would

have believed he was entitled by references to written or printed advertising material accompanying or made part of an application.

(8) Attemting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.